(3) Patient preference; or

(4) Referral.

C. When a readmission occurs as a result of an inappropriate discharge from the first admission, the first admission will be denied payment and the readmission will be considered a separate admission.

13.0 DISPROPORTIONATE POPULATION ADJUSTMENT

13.01 Disproportionate population adjustment or DPA eligibility. A Minnesota or local trade area hospital that is not state-owned, that is not a facility of the federal Indian Health Service, and that meets the criteria of items A to D is eligible for an adjustment to the payment rate.

A. A hospital that offers obstetric services must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medical Assistance recipients. For non-MSA hospitals the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

B. A hospital that did not offer non-emergency obstetric services as of December 21, 1987 or a hospital whose inpatients are predominately under 18 years of age is not subject to item A.

C. A hospital must have a base year Medical Assistance inpatient utilization rate that exceeds 1 percent.

D. A hospital must have a base year Medical Assistance inpatient utilization rate that exceeds the arithmetic mean for Minnesota and local trade area hospitals or a low-income inpatient utilization rate that exceeds .25, determined as follows:

Medical Assistance Inpatient Utilization Rate	=	Medical Assistance inpatient days divided by total inpatient days

If the hospital's Medical Assistance inpatient utilization rate is at the mean, the calculation is carried out to as many decimal places as required to show a difference.

Low Income Utilization Rate = [(Medical Assistance revenues and any cash subsidies received by the hospital directly from state and local government) divided by (total revenues, including the cash subsidies amount for patient hospital services)] plus [(inpatient charity care charges less the cash subsidies amount) divided by (total inpatient charges)]

For purposes of this section, "charity care" is care provided to individuals who have no source of payment from third party or personal resources.

13.02 Medical Assistance inpatient utilization DPA. If a hospital meets the criteria of §13.01, items A or B and the Medical Assistance inpatient utilization rate exceeds the mean in §13.01, item C, a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient utilization rate.

B. Add 1.0 to the amount in item A.

C. If a hospital meets the criteria of §13.01, items A or B and the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in §13.01, item C, the payment adjustment determined under item A is multiplied by 1.1, and added to 1.0.

13.03 Low income inpatient utilization DPA. If a hospital meets the criteria of §13.01, items A or B and the low-income inpatient utilization rate under item C, the payment adjustment is determined as follows:

A. Subtract .25 from the hospital's low-income inpatient utilization rate.

B. Add 1.0 to item A if item A is positive.

13.04 Other DPA. If a hospital meets the criteria of §13.01, items A or B and both the Medical Assistance inpatient utilization rate criteria and the low-income inpatient utilization rate criteria, the DPA is determined as described in §13.02.

13.05 Rateable reduction to DPA. If federal financial participation is not available for all payments made under §§13.01 to 13.04, the payments made shall be rateably reduced a percentage sufficient to ensure that federal financial participation is available for those payments as follows:

A. Divide the federal DPA limit by the total DPA payments to determine an allowable DPA payment ratio.

B. Multiply the result of item A by each hospital's DPA under §13.02 or §13.03.

C. Add 1.0 to the amount in item B.

13.06 Additional DPA. A DPA will be paid to eligible hospitals in addition to any other DPA payment as calculated under §§13.01 to 13.04. A hospital is eligible for this additional payment if it had:

A. Medical Assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total Medical Assistance fee-for-service payment volume. Hospitals meeting this criteria will be paid $1,515,000 each month beginning July 15, 1995.

B. A hospital is eligible for this additional payment if it had Medical Assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total Medical Assistance fee-for-service payment volume and is affiliated with the University of Minnesota. A hospital meeting this criteria will be paid $505,000 each month beginning July 15, 1995.

14.0 APPEALS

A hospital may appeal a decision arising from the application of standards or methods of the payment system. An appeal can result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that are discovered as a result of the submission of appeals will be implemented. Regardless of any appeal outcome, relative values shall not be recalculated.

The appeal will be heard by an administrative law judge according to Minnesota Statutes, chapter 14, or upon agreement by both parties, according to a modified appeals procedure established by the Department and the Office of Administrative Hearings. In any proceeding, the appealing party must demonstrate by a preponderance of the evidence that the Department's determination is incorrect or not according to law.

A. To appeal a payment rate or payment determination or a determination made from base year information, the hospital must file a written appeal request to the Department within 60 days of the date the payment rate determination was mailed to the hospital. The appeal request shall specify:

(1) The disputed items.

(2) The authority in federal or state statute or rule upon which the hospital relies for each disputed item.

(3) The name and address of the person to contact regarding the appeal.

B. To appeal a payment rate or payment change that results from a difference in case mix between the base year and the budget year, the procedures and requirements listed above apply. However, the appeal must be filed with the Department within 120 days after the end of the rate year. A case mix appeal must apply to the cost of services to all Medical Assistance patients that received inpatient services from the hospital. For a case mix appeal filed after July 1, 1997, the combined difference in case mix for Medical Assistance and General Assistance Medical Care, a State-funded program, must exceed five percent. For this paragraph, "hospital" means a facility holding the provider number as an inpatient service facility.

C. To appeal a payment rate or payment change that results from Medicare adjustments of base year information, the 60-day appeal period begins on the mailing date of the notice by the Medicare program or the date the Medical Assistance payment rate determination notice is mailed, whichever is later.

D. As part of the appeals process, hospitals are allowed to seek changes that result from differences in the type of services provided or patient acuity from the base year. This is necessary because of the time lag between the base year and the rate year. These case mix appeals are calculated after the rate year has finished. However, in a few situations such as the creation of a new program, it is prospectively evident that a case mix appeal will be successful. Therefore, in these cases, an agreement is drafted mandating a case mix appeal calculation at the end of the year and estimated payments are made on an interim basis.

15.0 OTHER PAYMENT FACTORS

15.01 Charge limitation. Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

15.02 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title III of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638,

or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

15.03 Small rural payment adjustment. Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds on March 1, 1988, and 100 or fewer Minnesota Medical Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 20 percent.

Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds and greater than 100 but fewer than 250 Minnesota Medical Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 15 percent.

The payment adjustment does not include Medicare crossover admissions in the admissions count nor are Medicare crossover admissions eligible for the percentage increase. Minnesota hospitals located in a city of the first class are not eligible for the payment adjustment.

The small rural payment adjustment is reduced by the amount of the hospital's DPA under §§13.01 to 13.05 and the hospital payment adjustment under §15.05.

15.04 Hospital payment adjustment. If federal financial participation is not available for all payments made under §§13.01 to 13.04 and payments are made under §13.05 or if a hospital does not meet the criteria of §13.01, items A or B, and the Medical Assistance inpatient utilization rate exceeds the mean in §13.01, item C, a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient rate.

B. Add 1.0 to the amount in item A.

C. If the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in §13.01, item C, the payment adjustment determined in item A is multiplied by 1.1 and added to 1.0.

D. Payment adjustments under this section are reduced by the amount of any payment received under §§13.01 to 13.04.

Payments made under this section are not disproportionate share hospital payment adjustments under §1923 of the Social Security Act.

15.05 Core hospital adjustment. Medical Assistance inpatient rates will increase as follows for admissions occurring July 1, 1993 to June 30, 1995:

A. For admissions to a children's hospital, increase nine percent. A children's hospital is an acute care facility engaged in furnishing services to inpatients who are predominantly individuals under 18 years of age.

B. For admissions to a public hospital with calendar year 1991 fee-for-service Medical Assistance inpatient dollar volume in excess of 13 percent of total calendar year 1991 fee-for-service Medical Assistance inpatient dollar volume, increase six percent.

C. For admissions to a teaching hospital operated by the University of Minnesota and having calendar year 1991 fee-for-service Medical Assistance inpatient dollar volume in excess of eight percent of total calendar year 1991 fee-for-service Medical Assistance dollar volume, increase three percent.

15.06 Rebasing adjustment. Payment to Minnesota and local trade area hospitals for admissions excluding Medicare crossovers, occurring on or after October 25, 1993 include a rebasing adjustment that is designed to prospectively compensate for an effective date of July 1, 1992 under the rates and rules in effect on October 25, 1993.

A. The adjustment to each hospital is calculated as the difference between payments made under this state plan and what was paid under each state plan in effect from July 1, 1992 to October 24, 1993, excluding the indigent care payment, with the following adjustments.

(1) Rates under this State plan are deflated 5.4 percent to remove the 1993 HCI. Rates are not deflated when the admissions under adjustment occurred in 1993.

(2) The core hospital increase is included when the admissions under adjustment occurred under a State plan that included it (July 1, 1993).

(3) The small rural payment adjustment is included when the admissions under adjustment occurred under a State plan that included it (October 1, 1992).

(4) The hospital payment adjustment is included when the admissions under adjustment occurred under a State plan that included it (July 1, 1993).

(5) The DPA is calculated using base year data under this State plan and the formulas under the State plan in effect for the admissions under adjustment (changed October 1, 1992).

(6) The cash flow payment adjustment under all State plans from July 1, 1992 to October 24, 1993 is deducted from the payment for admissions under adjustment.

B. Aggregate amounts owed to the hospital under item A are reduced by twenty percent. Payments for the cash flow payment adjustment are subtracted. The net difference is divided by 1.5 times the number of admissions under adjustment after mother and baby admissions are separated to derive a per admission adjustment. A hospital with an aggregate amount owed to the Department that exceeds one million dollars and has a payment reduction due to rebasing that exceeds twenty percent will have the net difference divided by 3.0 times the number of admissions under adjustment.

C. The rebasing adjustment will be added to or subtracted from each payment for admissions excluding Medicare crossovers, occurring on or after October 25, 1993 until the aggregate amount due to or owed by a hospital is fully paid.

D. The rebasing adjustment will occur over two periods.

(1) The first adjustment for admissions occurring from July 1, 1992 to December 31, 1992 and paid by August 1, 1993 begins with admissions occurring on or after October 25, 1993.

(2) The second adjustment for admissions occurring from January 1, 1993 to October 24, 1993 and paid by February 1, 1994 begins the later of February 1, 1994 or after the first adjustment is fully paid.

15.07 Out of state negotiation. Out-of-area payments will be established based on a negotiated rate if a hospital shows that the automatic payment of the out-of-area hospital rate per admission is below the hospital's allowable cost of the services. A rate is not negotiated until the claim is received and allowable costs are determined. Payments, including third party liability, may not exceed the charges on a claim specific basis for inpatient hospital services that are covered by Medical Assistance.

15.08 Psychiatric services contracts ~~for committed patients~~. The Commissioner has determined that there is a need for access to additional inpatient hospital psychiatric beds for persons with serious and persistent mental illness who have been ~~judicially~~ civilly committed or voluntarily hospitalized and can be treated and discharged within 45 days. In response, contracts with non-state operated hospitals to provide inpatient hospital psychiatric services to patients who will be dually committed to the non-state operated hospital and the State-operated regional

treatment center, or who have agreed to hospitalization, have been established. Payment rates for these inpatient psychiatric services are negotiated and established in the contracts executed under an open bidding process between the Commissioner and the hospitals.

A. Parameters related to the acceptance of a proposal other than cost include:

(1) the quality of the utilization review plan; ;

(2) experience with mental health diagnoses; and

(3) the commitment process.

B. Parameters related to acceptance of a proposal on a financial and cost basis include:

~~A.~~(1) payor of last resort/payment in full compliance assurances;

~~B.~~ (2) general experience operating within the Medicare/Medical Assistance programs; and

~~C.~~ (3) financial integrity.

C. Voluntary hospitalizations are included in the contracts under the following conditions:

(1) the Department and county must give prior approval;

(2) the hospitalization must be an alternative to commitment;

(3) the patient must have a past history of psychiatric hospitalization requiring extended inpatient psychiatric treatment; and

(4) the county would seek commitment if the patient did not agree to hospitalization.

Rates are established through the bid process with negotiation based on the cost of operating the hospital's mental health unit as derived from the Medicare cost report. The cost information, for comparison to a state-operated hospital, is adjusted to take into account average acuity and length of stay differences.

15.09 Medical education. In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional one-time payment for medical education for Federal Fiscal Year 2000 (October 1, 1999 through September 30, 2000) to the six Minnesota Medical Assistance-enrolled teaching hospitals with the highest number of Medical Assistance admissions in State Fiscal Year 1996. The Medical Assistance payment rate is increased as follows:

One-time Dollar Amount	x	(Total State Fiscal Year 1996 Medical Assistance admissions of a Minnesota Medical Assistance-enrolled teaching hospital) ÷ (Total State Fiscal Year 1996 Medical Assistance admissions of the six Minnesota Medical Assistance-enrolled teaching hospitals with the highest number of Medical Assistance admissions in that fiscal year)

In accordance with Code of Federal Regulations, title 42, section 447.253(b)(2), in no event shall the Medical Assistance payment exceed the Medicare upper payment and charge limits as specified in Code of Federal Regulations, title 42, section 447.272. Providers must reassign this payment to the Department of Health in accordance with Code of Federal Regulations, title 42, section 447.10(e). The Department of Health must transfer 100 percent of this payment to eligible providers, according to State law.

Methods and Standards for Determining Payment Rates for Inpatient Hospital Services Provided in Regional Treatment Center (RTCs) Programs for Persons with Mental Illness

1.0 PURPOSE AND SCOPE

This attachment describes the methods and standards for determining payment rates for inpatient hospital services for individuals age 65 and older in institutions for mental diseases and for inpatient psychiatric services for individuals under age 21. This description only applies to services provided in State-owned facilities.

Minnesota has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

2.0 METHODOLOGY

Payment rates are determined annually on a cost-related basis using Medicare principles of reimbursement as specified in *Provider Reimbursement Manual* - HCFA 15, parts I and II with the following exceptions.

2.1 **Interim Rates** are calculated on a per diem basis for each State fiscal year (July 1 to June 30) for individual treatment programs for mental illness. The sum of anticipated allowable costs is divided by the number of projected patient days. This amount is increased by a disproportionate share hospital (DSH) adjustment. Interim rates are approved for Medicaid by the Medicare intermediary and settlement is reached at the end of the year.

2.2 **Final Rates** are calculated by dividing total allowable costs by in-house patient days. This amount is increased by any DSH.

2.3 **Costs** include: salaries; current expenses (fuel, utilities food, drugs, and other expenses); repairs and betterment; depreciation of buildings and equipment; building bond interest; other capital requirements; and other expenses related to patient care, such as physician and ancillary services, central office support (program supervisory staff), collections administration for RTCs, other indirect costs (Department personnel, medical director, information systems, and program analysis), statewide support costs (central payroll, statewide payroll), and other State agency support to RTCs.